FLORIDA DEPARTMENT OF HEALTH

REFERRAL FORM

Please Type or Print Legibly

CLIENT AND FAMILY INFORMATION

Client's Name	Date of Birth (mm/dd/yy)	Social Security Number	Medicaid Number
Parent/Guardian Name			
Telephone Number	Mailing Address		

Referred To:
Address:

From (name of person making referral):	Title:	Telephone Number:
Agency:		
Address:		

Reason for Referral/Notes to Referral Agency:

LIST SERVICES AUTHORIZED

Rate Authorized:

☐ Applicable Medicaid Rate ☐ Up to _____ Dollars

☐ Per Contract ☐ No Payment Authorized

If on Medipass or HMO, indicate authorization number

Medipass/HMO #: _____

Expiration Date: _____

_____
Referring Person's Signature Date

Response to Referral Originator:

_____
Respondent's Signature Date

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